RESURRECTION CATHOLIC SCHOOL

Release for medication to be administered at school
School Year: _____

Student's name: _____ Date of birth: _____

Teacher: _____ Grade: _____

Medication: _____ Dosage: _____

Diagnosis/Reason for Medication: _____

Time of day medication is to be given: _____

Possible side effects: _____ Anticipated number of days medication

will be given at school: ____ days ____ weeks ____ end of school year

Is the student allergic to any medication? _____

Date: _____ Physician Signature: _____

I hereby give my permission for _____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication.

Date: _____ Parent Signature: _____

NOTE: the medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the medication, the dosage and number of days to be administered at school.